Smiths Group Services Corp.

Welfare Plan Summary Plan Description

For all Active Employees

In the Corporate, Detection, John Crane, Interconnect and Flex-Tek Laconia Site Division

Effective August 1, 2023

Contents

Introduction

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, “Evidence of Coverage Documents”), is intended to serve as the Summary Plan Description (“SPD”), as required by the Employee Retirement Income Security Act of 1974 (“ERISA”) for certain employees of Smiths Group Services Corp. (the “Company”). This SPD describes the following benefits provided by the Smiths Group Services Corp. Welfare Plan (commonly known as the “Smiths Plan” and also referred to in this SPD as the “Plan”) for eligible employees of the Corporate, Detection, Interconnect, John Crane, and the Laconia site Flex Tek division, and their eligible dependents. There are separate booklets and certificates of coverage for the benefit options which, together with the document, constitute the Summary Plan Descriptions.

- Medical (which includes prescription drug coverage)
- Dental
- Vision
- Long-Term Disability (LTD) (Basic and Buy-Up)
- Basic Life Insurance
- Supplemental Life Insurance
- Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D)
- Voluntary AD&D
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account*
- Wellness
- Employee Assistance Program (EAP)
- Voluntary Benefits (critical illness, accidental injury, hospital indemnity and, effective 8/1/24, legal benefits)

* *This benefit is not considered an ERISA benefit but is included in this document purely for your reference and convenience*

This booklet also summarizes some of the provisions of the Smiths Group Services Corp. Flexible Benefits Plan (referred to as “the Cafeteria Plan” or “Flexible Benefits Plan”) which provides you with the opportunity to pay for benefits on a pretax basis as described herein, as well as provides for the following benefit programs:

- Health Care Flexible Spending Account (Health Care FSA)
- Dependent Care Flexible Spending Account (Dependent Care FSA)*
- Health Savings Account*

**These benefits are not considered ERISA benefits but are included in this document purely for your reference and convenience.*

Additional details can be found in the separate Summary Plan Description (SPD) for the Flexible Benefits Plan.

To the extent required by applicable law, the group health coverage under the Plan will be provided in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), the Health Insurance Portability and Accountability Act ("HIPAA"), the Newborns' and Mothers' Health Protection Act ("NMHPA"), the Women's Health and Cancer Rights Act ("WHCRA"), the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), the Genetic Information Nondiscrimination Act ("GINA") and the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as the "ACA" or Health Care Reform).

Important Notice Regarding Health Care Reform and the Marketplace

The federal health care reform legislation, known as the Affordable Care Act (ACA) went into effect in 2011 for most health plans. Certain plans, such as the dental and vision plans, and health spending account are exempt. Under ACA you may also have the ability to purchase health coverage for yourself and your family members through the Health Insurance Marketplace (otherwise known as an Exchange). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if your employer does not offer you coverage under a health plan that is "affordable" and provides "minimum value." There are only certain times of the year that you can purchase coverage through the Marketplace unless you experience an event that allows you to purchase coverage through the Marketplace mid-year. You can find additional information regarding coverage available through the Marketplace at www.healthcare.gov or by calling 1.800.318.2596.

As required under ACA, each medical option also has a Summary of Benefits and Coverage (SBC). The SBCs are based on templates required by law which are intended to standardize the description of medical options so individuals can easily compare medical options. While the SBCs are concise "snapshots" of the options, they are not intended to take the place of your SPD or the official plan document. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents and the applicable SPD.

The LTD, Basic Life, Supplemental Life, Dependent Life, AD&D, Voluntary AD&D and Voluntary benefits are provided through insurance policies. The Medical, Dental, Vision and Spending Accounts benefits are self- insured by Smiths Group Services Corp. (and participating employers) and are administered pursuant to contracts with third party service providers, except that there may be specific benefit options that are HMOs or are fully insured. All benefits are summarized in this document and in the applicable Evidence of Coverage documents (or "EOCs", as defined below).

This summary should be read in connection with the EOCs (see Appendix A for a list of EOCs). The EOCs may be provided by the insurance companies, HMOs and service providers. If there is ever a conflict or a difference between what is written in this summary and the EOCs with respect to **the specific benefits provided**, the EOCs shall govern unless otherwise provided by any federal and state law. If there is a conflict between the EOCs and this SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, this document will rule.

The applicable EOCs for medical benefits describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. A directory of participating network providers will be provided, automatically, at no cost to you. You may also access provider directories on the insurance companies' and HMOs' websites, or you can call the insurance companies or HMOs at the phone numbers indicated in the EOCs. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified on towards the end of this document.

Smiths Group Services Corp. reserves the right to change, amend, suspend, or terminate this Plan and any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to the Plan, including but not limited to eligibility, coverage and benefit determinations under the Plan. Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the Plan. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties. With respect to the fully insured plans, the insurer makes all decisions regarding benefits payable and with respect to the self-insured plans, the claims fiduciary makes all decisions regarding benefits payable under the applicable benefit option.

Note that by adopting and maintaining these benefits, Smiths Group Services Corp. will not be deemed to have entered into an employment contract with any employee.

Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by Smiths Group Services Corp. or to interfere with Smiths Group Services Corp.'s right to discharge any employee at any time. The SPD provides summary information about the Plan and how it works and does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the Plan should not be interpreted as an implied or express contract or guarantee of employment. Smiths Group Services Corp.'s employment decisions are made without regard to benefits to which you are entitled.

Eligibility

Eligible Employees

Generally, you are considered an "eligible employee" and are eligible to participate in the Plan on your date of hire if you are:

- A regular full-time salaried or hourly employee of the following divisions of Smiths Group Services Corp. regularly scheduled to work at least 20 hours per week:

    - Corporate
    - Detection
    - John Crane
    - Interconnect
    - Flex-Tek – Laconia

If you are an hourly union Detection employee at the Edgewood location, you are eligible to participate in the Plan on the day following 90 days of continuous employment.

Individuals Not Eligible

You are not eligible to participate in the Plan if you are designated, in your employer's sole discretion, as:

- Regularly scheduled to work less than 20 hours per week
- A temporary employee,
- A leased employee,
- An independent contractor,
- A member of a collective bargaining unit, unless the collective bargaining agreement provides for your participation in the Plan,
- An employee of any other division of Smiths Group Services Corp. not listed above.

Please see the applicable EOCs for additional eligibility requirements.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

Eligible Dependents

Please see below and also the separate booklets for each benefit option for additional rules regarding eligibility.

You must provide proof of your dependents' eligibility upon request. False or misrepresented information will cause both your coverage and your dependents' coverage to be terminated (retroactively to the extent permitted by law) and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation unless otherwise required under the ACA rescission rules for the Medical Plan.

Medical, Dental and Vision

Your eligible dependents can be enrolled in the Medical, Dental and Vision coverage under the Plan only if you (the employee) are enrolled.

If you are married to another Smiths Group Services Corp. employee, you may enroll as an employee or a dependent under the Plan, but you cannot enroll as both a dependent and an employee. Eligible dependents may be enrolled under one employee's coverage only under the Plan.

The following dependents are eligible for Medical, Dental and Vision coverage offered under the Plan:

- Your legally married spouse;
- Your domestic partner (see "Domestic Partners" below)
- Your children who are under age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order ("QMCSO"); and
- Your unmarried, mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26 and was either (1) covered under the applicable benefit option immediately prior to attaining age 26 or (2) is enrolled during your initial enrollment period, if you are a new hire and your disabled child is over 26.

Your dependent children are:

- Your natural children;
- Stepchildren;
- Foster children;
- Legally adopted children and children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian prior to their attaining age 18 and who are chiefly dependent on you for support and maintenance.

The following individuals are not eligible dependents for Medical, Dental or Vision coverage:

- A child who is not a U.S. citizen or national or a resident of the U.S., Canada, or Mexico (except in the case of certain foreign adoptions);
- A parent of you or your spouse; and
- Grandchildren (unless legally adopted by you).

Dependent Life

The following are dependents for dependent life insurance offered under the Plan:

- Your legally married spouse or Domestic Partner;
- Your or your spouse's or your Domestic Partner's unmarried natural child, stepchild, or legally adopted child (or child placed for adoption) or foster child, until age 26.

However, your spouse, Domestic Partner or child is not an eligible dependent while:

- On active duty in the armed forces of any country
- Insured as an Employee of the Company

Health Care and Dependent Care Flexible Spending Accounts

Please refer to the separate SPD for the Flexible Benefits Plan for important details, including with respect to eligible dependents and eligible expenses.

In general, for purposes of the Health Care Flexible Spending Account your dependents include your spouse and children until the end of the year in which they turn age 26.

For the Dependent Care Flexible Spending Account include, dependent typically means:

- A child under age 13 who is your *qualifying child*,
- A disabled spouse who lives with you for more than one-half the year, and
- Any other relative or household member who receives more than one-half of his or her support from you, lives with you for more than one-half the year, is physically or mentally unable to care for him or herself, and who is not the *qualifying child* of the employee or any other individual.

Domestic Partners

Employees can enroll a same-sex or opposite sex domestic partner for coverage under the Company's plans (for all divisions except STS Laconia which does not cover opposite sex domestic partners) if the employee and his/her partner meet the following requirements:

- Be at least 18 years of age and mentally competent to consent to the contract,
- Not to be legally married to or legally separated from anyone else nor have had another domestic partner within the prior 24 months,
- Intend to remain each other's sole domestic partner indefinitely,
- Live together in the same principal residence for at least 12 months and intend to do so indefinitely,
- Be engaged in a committed relationship of mutual caring and support and are jointly responsible for each other's common welfare and living expenses,
- Not be related by blood closer than would prohibit marriage in the state the employee lives in, and
- Demonstrate their interdependence by at least 3 of the following:

    - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in policy,
    - Common ownership of a motor vehicle,
    - Driver's license or passport listing a common address,
    - Same automobile insurance policy,
    - Joint bank accounts or credit accounts,
    - Designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will, Assignment of a durable property power of attorney or health care power of attorney.

Imputed Income

If you elect coverage for a same-sex domestic partner or an individual to whom you have entered in a same-sex civil union under applicable state law (or their children), the value of the coverage provided to those individuals is not exempt from federal income tax unless the person is a "dependent" as defined in the Internal Revenue Code. In this case, the payments you are required to make for such coverage will be deducted from your salary on a pre-tax basis and then the total value of the coverage (as determined by Company) provided on behalf of your same-sex domestic partner or civil union partner (and their children) will be considered taxable income to you. You will not actually receive additional income in your paycheck, but the Company will withhold federal taxes on this additional "imputed" amount, and it will be reported on your Form W-2 for the year. The Company will treat enrolled domestic partners and their children as not qualifying as tax dependents under the Internal Revenue Code, unless you provide substantiation to the contrary.

It may also be necessary to impute income for state and/or local income tax purposes, depending on your place of residence.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child. You may obtain a copy of The Company's procedures governing QMCSO determinations, free of charge, by

contacting the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020, 1-866-330-6555.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

Notification

If you experience a change in status, you must notify the Company within 30 days in order to make a change in your election during the year.

The notice must be in writing and contain the change in status event, the date of the event, and your requested change and must be sent to the Smiths Group Benefits Center at the address in the following paragraph.

In addition, you must notify the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020 in writing within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage in order for you and your dependents to elect COBRA coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the EOCs provided by the applicable insurance companies and/or service providers.

Enrollment

New Employees

If you are an eligible employee, when you begin working at Smiths Group Services Corp., you will receive the information necessary to enroll in the Plan. You are eligible for and will automatically be enrolled in the following:

- Medical (which includes prescription drug benefits), in the option designated in the enrollment material, unless you waive coverage or affirmatively elect other coverage
- Basic Life
- Basic AD&D
- Employee Assistance Program

You must affirmatively enroll yourself and your eligible dependents within 30 days of your date of hire or eligibility date for:

- Dental
- Vision
- Supplemental Life
- Dependent Life
- Voluntary AD&D
- Basic Long-Term Disability
- Buy-Up Long-Term Disability
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account contributions
- Voluntary Benefits

You must also affirmatively enroll your dependents for Medical coverage. Otherwise, you will be enrolled for employee-only coverage, under the designated default option.

If you enroll in the HSA-Compatible Plan, you may be eligible to enroll in a Health Savings Account. You may not enroll in the Health Care Flexible Spending Account and the Health Savings Account. If you enroll in the Health Savings Account, you will not be eligible to enroll in the Health Care Flexible Spending Account and will not be eligible for the carryover. Please refer to the Flexible Benefits Plan SPD.

In addition, the IRS imposes additional rules as to who is eligible to maintain an HSA. Only those who meet these requirements are eligible to receive the employer contribution, if any, and to make HSA contributions. The amount of the HSA employer contribution will be determined by Smiths Group Services Corp. and announced to participants from time to time. Health Savings Account contributions also are subject to limits that apply under the Internal Revenue Code, and Smiths Group Services Corp. or limit the amount you may contribute to your Health Savings Account through the Cafeteria Plan if it appears that contributions to the HSA exceed any limit that applies to you. However, you are responsible for making sure you do not exceed the annual limit on HSA contributions that applies to you.

If you are eligible for Medicare or have other disqualifying coverage (such as can be reimbursed from a health care flexible spending account or have other medical coverage that is not considered a qualifying high deductible health plan), you are not HSA eligible Please refer to the IRS Publication 969 for more information.

If you do not enroll in Dental, Vision, Health Care or Dependent Care Flexible Spending Account or voluntary coverages within 30 days from your date of hire, you will have to wait until the next Open Enrollment period to enroll for coverage effective on the first day of the following Plan Year, unless you experience a change in status that permits an election change, or, for the Medical Plan, you are entitled to a special enrollment period. Similarly, if you enroll in or are deemed to enroll in Medical coverage because you don’t waive coverage within 30 days from your hire date, you will not be able to

make changes to your election until the next Open Enrollment period unless you experience a change in status that permits an election change or you are entitled to a special enrollment period.

Open Enrollment is held annually. This is your opportunity to enroll, change, or drop coverage. Changes are effective August 1 and remain in place through the following July 31 unless you experience an event that permits a mid-year election change, and you request a corresponding election change in the time and manner required.

If you do not enroll for Supplemental Life, Dependent Life, Voluntary AD&D, or Buy-Up Long-Term Disability coverage when you are first eligible, you may enroll mid-year if you have a change in status, but you will have to provide evidence of insurability and coverage is not effective until your enrollment is accepted by the insurer. The same rule may apply if you enroll in a later annual enrollment period. If evidence of insurability is required, you do not have coverage until you are accepted by the insurer (deductions of premiums is not evidence that you were accepted by the insurer).

Unless you are an hourly union Detection employee at the Edgewood location, your coverage under the Plan will begin on your date of hire. If you become eligible for coverage later than your initial hire, your coverage will begin on the date you become eligible for coverage. If you are an hourly union Detection employee at the Edgewood location, your coverage under the Plan will begin on the day following 90 days of employment. Your eligible dependents' coverage under the Plan will begin on the same date if you make the necessary elections within the necessary time period.

If you enroll yourself or a dependent in the Medical, Dental, Vision, Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account benefits mid-year due to a change in status, coverage will be effective as of the date of the applicable life event, unless otherwise provided in the applicable EOC.

Current Employees

Open Enrollment is held annually. This is your opportunity to enroll, change, or drop coverage. Changes are effective August 1. You'll receive information, including instructions on how to enroll, before Open Enrollment each year.

HIPAA Special Enrollment Events

If you do not enroll for Medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your eligible dependents' coverage is lost (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 30 days of the event. If you timely request a change, coverage will be effective the date of the event.

The Plan allows a HIPAA special enrollment for employees or dependents (i) whose coverage under a Medicaid plan or a state child health plan (CHIP) is terminated as a result of loss of eligibility or (ii) who become eligible for Medicaid or CHIP coverage.

Employees have 60 days from the date of termination of or eligibility for Medicaid/CHIP coverage to request enrollment under the Plan. If you request this change, coverage will be effective the day of your completed request for enrollment.

To request special enrollment or obtain more information, contact the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020, 1-866-330-6555. Please see the section at the beginning of this SPD regarding the temporary extensions of deadlines that apply due to the pandemic, effective March 1, 2020.

Contributions

Employee Contributions

You pay your share of the cost of Medical, Dental and Vision coverage on a pre-tax basis (see below for more information), unless your enrolled eligible dependents do not qualify for tax-free coverage. If your enrolled eligible dependents are not eligible for tax-free coverage, you will pay your contributions for their coverage on an after-tax basis.

The level of contribution is determined by the Company and can be changed at any time. Please refer to the Smiths Group Benefits Center website for information about contributions, wellness credits, and surcharges, such as the spousal surcharge and tobacco surcharge with respect to medical plan coverage.

Contributions to the Health Care and Dependent Care Flexible Spending Account and Health Savings Account are also on a pre-tax basis. By enrolling, you are agreeing to have your salary reduced by the appropriate contribution amount on a before-tax basis.

If you are enrolled for Supplemental Life, Dependent Life, Voluntary AD&D and Buy-Up Long-Term Disability coverage, and/or Voluntary Benefits you pay the cost for coverage on an after-tax basis, unless otherwise provided in the enrollment material.

Contributions are deducted from employee’s paychecks based on their elected level of coverage.

You do not pay Social Security taxes on the pretax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current

taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits. Your pretax contributions are not subject to federal income tax but may be subject to state and local income tax.

Employees who are on leave and not receiving regular paychecks will be required to make any required contribution directly to the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020. Failure to make timely payments will result in the termination of coverage.

Section 125 Plan – Premium Conversion

The Company has established a premium conversion plan under Internal Revenue Code Section 125 for you to be able to pay your contributions for the Medical, Dental and Vision coverages provided under the Plan on a pre-tax basis. In exchange for this tax benefit, your elections cannot be changed during the year, except in limited circumstances as explained in the separate SPD for the Flexible Benefits Plan (and summarized below).

Making Changes to Your Coverage During the Year

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the Plan Year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following Plan Year (August 1 through July 31). The election change rules are explained in the separate Flexible Benefits Plan SPD; a brief summary is provided below.

If you experience one of the events described below and want to make a corresponding change to your coverage due to such event, you must notify the Company within 30 days of the status change (60 days in the event of a special enrollment involving Medicaid or a State child health plan ("CHIP")).

Changes in Status: You may be able to change your Medical, Dental, Vision, Health Care and Dependent Care Flexible Spending Account elections during the Plan Year if you experience a change in status. Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.). Remember that you are required to drop individuals who cease to meet the eligibility requirements on a timely basis. Examples of changes in status include:

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.

- **Number of eligible dependents:** Any event that changes your number of eligible dependents including birth, death, adoption, and placement for adoption.

- **Employment status:** Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:

  - Beginning or ending employment.
  - A strike or lockout.
  - Starting or returning from an unpaid leave of absence.
  - Changing from part-time to full-time employment or vice versa; and A change in work location.

- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances.

- **HIPAA Special Enrollment Events**: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA);

- **FMLA leave:** Beginning of or, if coverage terminated while on FMLA leave, returning from an FMLA leave.

QMCSOs

If a Qualified Medical Child Support Order ("QMCSO") requires a group health plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

Coverage During Leave of Absence

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence, contact the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020, 1-866-330-6555.

FMLA Leave

The federal Family and Medical Leave Act ("FMLA") allows eligible employees to take a specific amount of unpaid leave for certain reasons, such as serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded in active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. See Human Resources for more information about what leave is

available under the FMLA. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty.

If you take FMLA leave, you may continue your group health coverage (Medical, Dental, Vision, and Health Care Flexible Spending Account coverage) coverage for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute your share of the cost of coverage during the leave, paying for coverage during your leave on an after-tax basis (if required). You also have the option to suspend your coverage during the leave. **For additional information on FMLA leaves, please contact the Smiths Group Benefits Center, PO Box** 9920, Providence, RI 02940-4020, 1-866-330-6555.

Please refer to the separate SPD for the Flexible Benefits Plan for more information regarding the effect of leaves on your Health Care and Dependent Care Flexible Spending Accounts.

Your Basic Life, Basic AD&D coverages will continue during an FMLA leave. Your Supplemental Life, Dependent Life, Voluntary AD&D, LTD, and Voluntary Benefits coverage will continue during FMLA leave if you continue to pay the required contributions during your leave or as otherwise required by the Plan Administrator. Contact HR to discuss how to pay for benefits while you are on a leave.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions. If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage even if you did not continue your coverage during the FMLA leave.

Military Caregiver Leave under FMLA

An eligible employee who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. An eligible employee can also take leave to care for certain veterans with a serious illness or injury incurred or aggravated in the line of duty while on active duty and that manifested itself before or after the veteran left active duty. Military caregiver leave is also allowed for an eligible employee to care for current service members with serious injuries or illnesses

that existed prior to service and that were aggravated by service in the line of duty while on active duty.

Military caregiver leave is available during a single 12-month period during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (http://www.dol.gov/compliance/laws/comp-fmla.htm).

Depending on the state you live in, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Military Leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Health Care Flexible Spending Account coverage for up to 24 months as long as you give the Company advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your total leave, when added to any prior periods of military leave from The Company, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

All required health coverage will continue during military leave. All other coverages will terminate during your military leave.

If you are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA balance as a taxable cash distribution by the last day of the FSA Plan Year.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at the Company, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period.

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. (See COBRA section below.) Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Continuation of Benefits during an Approved Leave of Absence (other than FMLA or USERRA Leaves)

If you take an approved leave of absence (other than pursuant to the FMLA or USERRA), your coverage under the Plan will continue during your approved leave of absence subject to timely payment of the required premium or contribution as follows:

- Coverage under the medical, dental and vision benefit options may be continued at active employee rates for 16 weeks and then COBRA continuation coverage will be offered; and

- Coverage under the non-health benefit programs, such as life, AD&D and the voluntary benefit programs, will continue during your approved leave (or such shorter period of time described in the applicable EOCs) provided you pay the required premiums.

Please refer to the separate SPD for the Flexible Benefits Plan for more information regarding the effect of an approved leave of absence on your Health Care and Dependent Care Flexible Spending Accounts.

If your leave of absence is paid, the cost of your coverage will be deducted from your pay if there is sufficient pay to cover the required deductions. If your leave of absence is unpaid, you will be responsible for submitting payments for the required premium or contribution on a timely basis to continue coverage, otherwise your coverage will be terminated. You should receive additional information after your leave begins, but you are responsible for paying for your coverage in a timely manner even if you do not receive an invoice.

The insured benefit programs may limit your ability to continue to participate in the benefit program during an approved leave of absence. You should review the booklets for those benefit programs for additional information.

Your coverage may terminate before the end of your approved leave of absence if any of the termination events described below occur, including your failure to pay the required contributions for coverage on a timely basis. For additional information regarding your continued participation in the Plan during a leave of absence, you should contact the Smiths Group Benefits Center, PO Box 9920, Providence, RI 02940-4020, 1-866-330-6555.

When Coverage Ends

Your coverage will terminate on the earliest of the following dates:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan or benefit option;
- The day you cease to be an eligible employee. This includes your death, reduction in hours, or termination of active employment (benefits can typically be continued for up to 4 months during an unpaid leave);
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- The date you report for active military service unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act ("USERRA") as explained in the *Military Leave* section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits are described in the EOCs.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the EOCs. In addition, their coverage will terminate:

- The day the Company terminates all dependent coverage under this Plan or applicable benefit option, should the Company elect to do so;
- For Medical, Dental and Vision coverage, the day a dependent child attains age 26 (unless he or she is mentally or physically disabled, unmarried and primarily depends on you for support);
- The day on which your legally married spouse, domestic partner or child is no longer considered an eligible dependent (for example, date of divorce);
- Your dependent becomes covered as an employee;

- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;

- You or your dependent dies.

- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your EOCs for more information on conversion.

In general, the Company is not allowed to rescind (i.e., retroactively cancel or terminate) your (or your dependent's) medical plan coverage once you (or your dependents) become covered under the Plan. However, your (and/or your dependent's) coverage under the Plan may be rescinded (i.e., cancelled or discontinued with a retroactive effective date) if you (and/or your dependent) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of this plan. For example, if the Company determines that you have enrolled an individual who does not meet the Plan's eligibility requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such Plan ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and the Company reserves the right to rescind your (and/or your dependent's) Plan coverage to the full extent permitted by law. If the Company seeks to rescind medical coverage for fraud or an intentional misrepresentation of a material fact, the Company will provide at least 30 days advance written notice to each participant who would be affected before coverage is rescinded. Your (and/or your dependent's) coverage also may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances without the Company having to provide 30 days advance written notice.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations. The following paragraphs generally explain COBRA coverage, when it may become available to you and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA is not provided to domestic partners, but if you elect COBRA, you may enroll your domestic partner as a dependent.

COBRA applies to group health plans, which includes the Medical, Dental, Vision, EAP and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by the Company (such as Life, Disability, AD&D or Voluntary benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

Please examine your options carefully before declining this coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Smiths Group Services Corp. (the "Plan Administrator"):

Smiths Group Benefits Center
PO Box 9920
Providence, RI 02940-4020
phone 866-330-6555

What is COBRA Coverage

COBRA coverage is a temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to the Smiths Group Benefit Center, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights.

Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment

opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment on a timely basis.

Who Is Covered

Employees

If you are an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualified events occurred:

- A reduction in your hours of employment with the Company or
- The termination of your employment with the Company (for reasons other than your gross misconduct)

Spouse

If you are the spouse of an employee of the Company, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of any of the following qualifying events (note that COBRA is not offered to domestic partners):

- The death of your spouse;
- The termination of your spouse's employment with the Company (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with the Company; or
- Divorce or legal separation from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events happen:

- The death of the parent-employee;
- The termination of the parent-employee's employment with the Company (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or

- You, the dependent child, cease to meet the definition of a “dependent child” under the Plan.

FMLA

If you take a leave of absence that qualified under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will have the right to elect COBRA if:

- You were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and

- You lose group health coverage under the Plan because the employee does not return to work at the end of the leave.

COBRA coverage will begin on the earliest of the following to occur:

- When you definitively inform the Company that you are not returning at the end of the leave; or

- The end of the leave, assuming you do not return to work.

Addition of Newly Eligible Child and Other Dependents

If you, the former employee of the Company, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also a qualified beneficiary. In accordance with the terms of the Plan’s eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the Company (see contact information below) with notice of the new child’s birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the Company within 30 days, you will not be offered the option to elect COBRA coverage for the newly acquired child.

Other dependents (other than children born to, adopted by, or placed for adoption with the employee for whom timely notice is provided) will not be considered qualified beneficiaries, but may be added to the employee’s continuation coverage, if enrolled in a timely fashion, subject to the Plan’s rules for adding a dependent.

QMCSO

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (“QMCSO”) received by the Company during the

covered employee's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify the Company of any of these three qualifying events.

For a qualifying event which is a divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify the Company (see contact information below) in writing within 60 days of the date of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the employee who is or was covered under the Plan.
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event.
- The qualifying event giving rise to COBRA coverage.
- The date of the qualifying event.
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if the Company requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, or marriage license.

You must mail or hand-deliver this notice to the COBRA Administrator at the address listed below under Contact Information, unless otherwise specifically provided on the COBRA election notice sent by the COBRA Administrator.

Once you, your spouse, or your dependent child has notified the Company, the information and election form you, your spouse, or your dependent children need to elect continuation coverage will be mailed to you within 14 days by the COBRA Administrator.

After you receive the information and election form, you and your eligible dependents then have 60 days from the date coverage ends or the date this information package is mailed to you (whichever is later) to accept or decline continuation coverage.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

How to Elect COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to:

WageWorks
P.O. Box 226101
Dallas, TX 75222-6101
website: mybenefits.wageworks.com.
Phone: 877-630-7215

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, you must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan.

Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you return your election form waiving your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child may elect different coverage than the employee elects.

A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

Coverage

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When you complete the election form, you must notify the Company if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement.

Health Care Flexible Spending Account COBRA Coverage

COBRA coverage under the Health Care Flexible Spending Account will be offered only through the end of the year, and only to qualified beneficiaries losing coverage who have underspent accounts. Please refer to the separate SPD for the Flexible Benefits Plan for more information.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. **If you do not make your first payment for COBRA coverage within 45 days after the date of your timely election, you will lose all COBRA rights under the Plan.** Thereafter, payments are due by the first day of each month to which the payments apply

(payments must be postmarked on or before the end of the 30-day grace period**). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator at the address listed below under Contact Information.

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care Flexible Spending Account ends on the last day of the Plan Year in which the qualifying event occurred. COBRA coverage for the Health Care Flexible Spending Account cannot be extended under any circumstances.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 60th day after the covered employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To qualify for this disability extension, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination BOTH:

1) within 60 days after the latest of:

i) the date of the disability determination by the SSA,

ii) the date on which the qualifying event occurs,

iii) the date on which you lose (or would lose) coverage under the Plan, or

iv) the date on which you are informed of both the responsibility to provide this notice and the Plan's procedures for providing such notice to the COBRA Administrator, **AND**

2) before the original 18-month COBRA continuation coverage period ends. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event.
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled.
- The date that the Social Security Administration made its determination of disability.
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and the signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand-deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made, and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the Plan for an active employee or dependent). If you experience a second qualifying event, COBRA coverage for a spouse or dependent child can be extended from 18 months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active participant). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event.
- The second qualifying event.
- The date of the second qualifying event.
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- The Company no longer provides group health coverage to any of its employees.
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end no sooner than the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant not receiving COBRA coverage (such as fraud). In addition, The Company reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage. The Company, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the

qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Contact Information

If you have any questions about COBRA coverage or the application of the law, please contact:

Smiths Group Benefits Center
PO Box 9920
Providence, RI 02940-4020

COBRA Administrator WageWorks
P.O. Box 226101
Dallas, TX 75222-6101
website: mybenefits.wageworks.com.
Phone: 877-630-7215

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Company informed of any changes in your and your family members' addresses. You should also keep a copy, for your records, of any notices you send to the Company.

Covered and Non-Covered Services

Refer to the EOCs provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses, and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Your Right to Privacy and Security

HIPAA requires employer health plans to maintain the privacy and security of your health information and to provide you with a notice of the Plan's legal duties and privacy and security practices with respect to your health information. The Plan's Notice of Privacy Practices ("Notice") will describe how the Plan may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the Notice will describe your rights with respect to your health information.

If you have a complaint about the way that your personal health information is handled by the Company or Claims Administrator, you are encouraged to share your complaint with the Company by calling the Plan Administrator.

Please refer to the Plan's Notice for more information. You may request a copy of the Notice from the Plan Administrator or Privacy Officer. The Notice can also be found at smithsgroupbenefitscenter.com/plan-documents/.

Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

This notice applies to services provided on or after January 1, 2023. This notice does not apply to separate dental and vision coverages or to the extent not required by law.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or a deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact your health plan using the contact information on the back of your health ID card. You may also contact the Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms/nosurprises/consumers for more information about your rights under federal law.

Employee Assistance Program

The EAP provides confidential counseling and referral resources through Lyra at no cost to you. You may contact Lyra at (877) 331-4678 or online at smiths.lyrahealth.com. Counseling support and crisis consultation is available 24 hours a day, seven days a week. Lyra also provides work life services to help you work through personal life obstacles. These services include legal, identity theft, financial, and dependent care services. You may book an appointment in person or via live video, and your utilization of the EAP is completely confidential. Lyra does not share information with Smiths Group that identifies which individuals are in care unless you request that Lyra share this information.

EAP counseling services are available to you, your spouse or domestic partner and your dependents (up to age 26). The EAP covers up to 16 sessions per plan year for the cost of outpatient therapy and mental health coaching services. If more sessions are needed, covered persons may be referred to other health providers/professionals.

Covered persons should also review the mental health benefits that may be available to them under their medical plan coverage. The EAP also covers the cost of your first consultations with work life services, after which you will be able to pay a discounted fee if you choose to continue engagement with the service.

Some of the problems that can be addressed through the EAP include:

- Family, relationship or marital problems
- Emotional well-being and life improvement issues
- Stress and anxiety with work or family
- Drug and alcohol dependence
- Debt management
- Grief
- Eating disorders like anorexia
- Conflicts at work
- Job stress
- Crisis situations
- Questions about legal or financial concerns
- Questions about child or elder care

The goal of the EAP is for you to feel better and get back to living your life, not to remain in therapy indefinitely. If you reach your 16-session limit for the year, and your therapist determines you would benefit from additional care, you may elect to continue working with your Lyra provider, but any future sessions would require out-of-pocket payment. You may be able to submit claims to your medical plan to cover part of the cost of care if your plan includes partial reimbursement for out-of-network providers. Alternatively, you may opt to find a provider who is in-network with your medical plan.

Services that are not covered include: psychiatry, inpatient or residential treatment, hospitalization (including partial), intensive outpatient treatment, emergent care, long-term care or counseling, prescription medication, autism spectrum disorder treatment, services for remedial education, executive coaching, and non-evidence-based behavioral health care.

How to get started:

1. Sign up online at smiths.lyrahealth.com

2. Complete the brief questionnaire to receive your personalized recommendations
3. Review high-quality providers matched to your needs
4. Book appointments online with a therapist or coach, or tap into self-care apps
5. Start feeling better in just a few sessions

For additional information about the EAP benefits, you should contact Lyra. The contact information is provided later in this document.

Wellness Programs

From time to time the Plan may offer wellness programs designed to promote the health and wellbeing of all employees. These wellness programs may provide financial incentives to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health “coaching” and participate in disease management programs, provide on-line education tools, etc.

These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Company money. Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of open enrollment material or other communication.

Financial incentives for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Smiths Group Benefits Center at 1-866-330-6555 and we will work with you (and if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Health Care Flexible Spending Account Benefits

The Health Care Flexible Spending Account may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage. Please refer to the separate SPD for the Flexible Benefits Plan for details of how this account works, the amount you can contribute, the benefits available, limitations, and requirements regarding claims and appeals of adverse benefit determinations.

Remember that IRS regulations stipulate that you must use the full amount of money in your Health Care Flexible Spending Account for expenses incurred during the applicable Plan Year (or the related grace period, if one applies) or forfeit what remains. Beginning August 1, 2024, you may be eligible to carryover some of the unused

amounts in your Health Care Flexible Spending Account at the end of the year but the amount that you can carryover each year is limited and you will forfeit unused amounts that exceed the limit for that year. With this **"use it or lose it"** rule, it is extremely important that you carefully plan your contributions to your Health Care Flexible Spending Account. For additional information, please refer to the SPD for the Flexible Benefit Plan.

You may not use money in your Health Care Flexible Spending Account to pay dependent day care expenses and vice versa. You may not switch money between the two accounts.

Dependent Care Flexible Spending Account Benefits

The Dependent Care Flexible Spending Account may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your spouse to work. Please refer to the separate SPD for the Flexible Benefits Plan for details about this account, the maximum contributions, eligible expenses, and claims rules. You can use this account to reimburse yourself for eligible expenses incurred during the applicable Plan Year (and the related grace period, if one applies). The grace period is ending with the plan year that ends July 31, 2024. For additional information, please refer to the SPD for the Flexible Benefit Plan.

Use It or Lose It

It is important that you not contribute more than the dependent care expenses that you expect to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care Flexible Spending Account for expenses incurred during the Plan Year (and applicable grace period, if any).

With this **"use it or lose it"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care Flexible Spending Account. Contribute only as much as you expect to claim during the Plan Year, or you will lose it. For additional information, please refer to the SPD for the Flexible Benefit Plan.

You may not use money in your Dependent Care Flexible Spending Account to pay health care expenses and vice versa. You may not switch money between the two accounts.

Claims and Appeal Process

Filing a Claim

The claims filing procedures are set forth in the EOCs, which are listed in Appendix A. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims

Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

For purposes of the Plan's claims procedures, the term "you" includes any participant or beneficiary making a claim, inquiry or appeal and the authorized representative of such person. You must follow the Plan's procedures for appointing an authorized representative unless your claim is an urgent care claim. For additional information regarding these procedures, you should contact the Plan Administrator or Claims Administrator. These procedures may require the use of specific forms. If your claim is an urgent care claim, you may appoint your health care provider to act as your authorized representative without following these procedures. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

In general, when you need to file a claim use the addresses listed in the EOCs, on the applicable claims form, or below. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of the Plan. Claims forms are available from the Claims Administrator.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the EOCs. In general, any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claims Administrators – Fully Insured

Smiths Group Services Corp. provides the following benefits under the Plan through contracts with the insurance companies listed below. The BCBS of IL Medical, Life, Supplemental Life, Dependent Life, AD&D, Voluntary AD&D, LTD benefits, and the Voluntary Benefits of the Plan are insured under contracts with the insurance companies listed below. The insurance companies administer claims and appeals for those benefits and are solely responsible for providing benefits.

Basic, Supplemental & Dependent Life, Accidental Death and Dismemberment (AD&D), Voluntary AD&D	Prudential Insurance Company of America Group Life Claim Division P.O. Box 483 Livingston, NJ 07039-2729 800-524-0542
Long-Term Disability (LTD) Insurance	Prudential Insurance Company of America Disability Management Services P.O. Box 13480 Philadelphia, PA 19101 877-889-4885
Blue Cross Blue Shield of Illinois (BCBS of IL)	Blue Cross Community Health Plans Attn: Grievance and Appeals Unit P.O. Box 27838

	Albuquerque, NM 87125-9705. Fax: 1-866-643-7069
Voluntary Benefits **Group Critical Illness Insurance,** **Group Accidental Injury Insurance,** **Group Supplemental Hospital Indemnity**	Aflac/Continental American Insurance Company P.O. Box 84075 Columbus, Georgia, 31993-9103 800-433-3036
HMSA-Hawaii	HMSA - Hawaii Medical Service Association P.O. Box 860 Honolulu, HI 96808 1-800-776-4672
Aetna International	Aetna 151 Farmington Ave Hartford, CT, 06156 800-231-7729
Cigna-Guam	Cigna 900 Cottage Grove Rd. Bloomfield, Connecticut, 06002 (860) 226-6000
Voluntary Legal Benefits (effective 8/1/24)	MetLife Legal Plans 1111 Superior Avenue Cleveland, OH 44114-2507 1-800-821-6400

Claims Administrators – Self-Insured

The Medical (which includes Prescription Drug benefits), Dental, Vision, EAP, Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Account benefits are self-insured. The Company has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment for the flexible spending accounts. However, the claims administrator for Medical, Prescription Drug, Dental, and Vision benefits is the fiduciary with the authority to determine claims and appeals for those benefits. The self-insured benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.

Medical	Anthem Blue Cross and Blue Shield P. O. Box 166 Indianapolis, IN 46206 www.anthem.com.
Prescription Drug	CVS Caremark Claims Department PO Box 52136 Phoenix, AZ 85072-2136

Dental	Delta Dental Administrative Offices One Delta Drive Mechanicsburg, PA 17055-6999 (717) 766-8500 Toll free: (800) 932-0783 TTY/TDD: 888-373-3582 www.deltadentalins.com
Vision	EyeMed Vision Care 800-334-7591 www.eyemedvisioncare.com Plan IDs: Core Plan: 9681719; Enhanced Plan: 1006166
Spending Accounts	WageWorks/Health Equity P.O. Box 226101 Dallas, TX 75222-6101 website: mybenefits.wageworks.com. Phone: 877-630-7215
EAP	Lyra 270 East Lane Burlingame, CA 94010 website: smiths.lyrahealth.com Phone: 877-331-4678

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that the insurance contracts and other agreements with claims administrators may contain somewhat different claims and appeals procedures and if so, those rules will apply. See the EOCs for more information.

Authorized Representatives

You may appoint an authorized representative to act on your behalf for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims. If you need to appoint an authorized representative, you must follow the rules and procedures of the Claims Administrator for such claim or appeal. In the case of an urgent health care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

To the extent the Claims Administrator has no rules or procedures, or does not impose stricter requirements, your appointment of an authorized representative must follow these requirements –

- must be in writing and dated, AND
- must clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative, AND
- must be signed by you, AND
- must satisfy any other legal requirement applicable to appointments under applicable law, AND

- must be approved by the Plan Administrator in writing.

The Plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations. If you appoint an authorized representative, notices and other communications will go to you and your authorized representative unless the Plan Administrator specifies otherwise. You should contact the Plan Administrator with any questions or to qualify someone as your authorized representative.

Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The procedures differ for health plan claims, disability claims, life insurance claims and claims under other programs. Please be sure to review the procedures set forth in the applicable EOC for the benefit under which a claim is being made.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim,"

depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit or rescission of coverage regardless of whether the rescission has an adverse effect on a particular benefit at the time of the decision. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan.
- Benefit not a covered benefit.
- An imposition of pre-existing condition, source-of-injury, network exclusion, or other limitation on otherwise covered benefits.
- Utilization review.
- A service being characterized as experimental or investigational or not medically necessary or appropriate.
- A rescission of coverage, regardless of whether the rescission had an adverse effect on any particular benefit;
- A concurrent care decision;
- Any other reason for which a benefit is not payable under the terms of the applicable program.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 ("ERISA"). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In advance of an adverse benefit determination under the medical plan, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan to give you a reasonable opportunity to respond prior to the date of the adverse benefit determination.

In the event of an adverse benefit determination, including a rescission of coverage under the medical plan, the claimant will receive notice of the determination. The notice will include:

- Information sufficient to identify the claim involved (i.e., date of service, health care provider and claim amount);
- A notice of the availability, upon request, of the diagnosis and treatment codes (and their meanings);
- The specific reasons for the adverse determination.
- The specific plan provisions on which the determination is based.
- A request for any additional information needed to reconsider the claim and the reason this information is needed.
- A description of the Plan's appeal and external review procedures and the time limits applicable to such procedures.
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- If any internal rules, guidelines, protocols, or similar criteria was used as a basis for an adverse determination involving health or disability claims, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited appeal and external review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

In addition, for disability claims filed after April 1, 2018, a notice regarding a denial of benefits will include:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the benefit determination;

and (c) a disability determination regarding the claimant presented to the Plan made by the Social Security Administration;

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request) or a statement that the same does not exist;

- If the claim was denied based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the disability plan to your medical circumstances (or a statement of the right to receive such an explanation upon request and without charge);

- The Plan will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided (as described above) to give the claimant a reasonable opportunity to respond prior to the date; and If such determination is based on a new or additional rationale, the Plan will provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to give the claimant a reasonable opportunity to respond prior to that date; and With respect to an adverse decision on review, the applicable contractual limitations imposed by the disability plan that apply to the right to bring legal action following the appeal, including the calendar date on which such period expires.

- The individual who decides the appeal will not be the same individual who decided the initial claim denial and will not be that individual's subordinate. Independent medical or other advice may be secured, and you may be required to provide other evidence, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The appropriate named fiduciary of the Plan will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment. The professional engaged for purposes of a consultation will be an individual who was not consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual. The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.

  Any notice of adverse determination provided with respect to disability benefits will be provided in a culturally and linguistically appropriate manner. Please be sure to refer to the disability plan policy or booklet for additional information.

Time Frames for Initial Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days. Dental, Vision and Health Care Flexible Spending Account claims are all considered non-urgent "post-service" claims.

	Medical (which includes Prescription Drug), Dental, Vision and Health Care Flexible Spending Account Plans				Long-Term Disability	Life Insurance, Dependent Life, Supplemental Life, AD&D and Voluntary AD&D
	Urgent Care Claims	***Non-Urgent "Pre-Service" Claims***	***Non-Urgent "Post-Service" Claims***	***"Concurrent Care" Decision to Reduce Benefits***		
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (*whether adverse or not*) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends. *	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends. *	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends. *	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.

	Medical (which includes Prescription Drug), Dental, Vision and Health Care Flexible Spending Account Plans				Long-Term Disability	Life Insurance, Dependent Life, Supplemental Life, AD&D and Voluntary AD&D
	Urgent Care Claims	***Non-Urgent "Pre-Service" Claims***	***Non-Urgent "Post-Service" Claims***	***"Concurrent Care" Decision to Reduce Benefits***		
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.	You have at least 45 days to provide any missing information.	N/A	You have at least 45 days to provide any missing information.	No rule.

**15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.*

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing and should be filed with the appropriate Claims Administrator. This request should include:

- The claimant's name and ID number as shown on the ID card
- The provider's name
- The date of medical service
- The reason you disagree with the denial and
- Any documentation or other written information to support your request.

To the extent applicable under the ERISA claims procedures (based on the type of claim and appeal and see above regarding special rules for disability claims):

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit

determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. For medical claims, you also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the below chart.

The Claims Administrator will provide you with written notification of the Plan's determination on review, within the time frames described below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review.
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA Section 502 following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; (for health and disability claims)
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; (for health and disability claims) and A description of the

voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the EOCs for that benefit. Please consult the EOC for the specific benefit involved. Where not otherwise covered by the EOCs, the following procedures will apply.

The time frame for filing an appeal starts when you receive written notice of an adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may be delivered by telephone, facsimile, or other available expeditious methods. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	Medical (which includes Prescription Drug), Dental, Vision and Health Care Flexible Spending Account Plan			**Long-Term Disability**	**Life Insurance, Dependent Life, Supplemental Life, AD&D and Voluntary AD&D**
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Period for Filing Appeal	You have no more than 180 days.	You have no more than 180 days.	You have no more than 180 days.	You have no more than 180 days.	You have no more than 60 days.

	Medical (which includes Prescription Drug), Dental, Vision and Health Care Flexible Spending Account Plan			Long-Term Disability	Life Insurance, Dependent Life, Supplemental Life, AD&D and Voluntary AD&D
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*		
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period "tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

** An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.*

Additional Requirements under the Affordable Care Act ("ACA")

Notwithstanding the foregoing, the Plan will comply with the applicable requirements of the ACA relative to all claims for medical benefits (unless the benefit is an "excepted benefit" to which the Affordable Care Act does not apply, as determined by the Claim Administrator), including but not limited to the following:

- **Opportunity to Present Evidence and Testimony.** Claimants shall be given the opportunity to present evidence and testimony as part of the appeals process. The terms "evidence" and "testimony" shall be interpreted in accordance with Department of Labor guidance;

- **Disclosure of New Rationale and Opportunity to Respond.** In the event the Plan (or the entity hearing an internal appeal of an adverse benefits determination on behalf of the Plan) considers, relies upon or generates new or additional evidence in

connection with the claim, or is considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Plan will advise the claimant in advance of the determination of the new evidence or rationale being considered, and shall allow the claimant no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event the claimant will be provided no less than two (2) days to respond to the new evidence or rationale;

- **No Conflict of Interest.** To the extent Plan personnel are involved in the claims process, the Plan will not consider in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any claimant, whether or not such individual is likely to support the denial of benefits to a claimant; and

- **External Review.** Except in the case of a medical plan option that is grandfathered, external review is available for final adverse benefit determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final adverse determinations that relate to a failure to meet the eligibility requirements under the Plan.

Exhaustion of Administrative Procedures Required

A claim or action (i) to recover benefits allegedly due under the Plan or by reason of any law, (ii) to enforce rights under the Plan, (iii) to clarify rights to future benefits under the Plan, or (iv) that relates to the Plan and seeks a remedy, ruling or judgment of any kind against the Plan or a Plan fiduciary or party in interest (collectively, a "Judicial Claim"), may not be commenced in any court or forum until after the claimant has exhausted the Plan's claims and appeals procedures, including, for these purposes, any voluntary appeal right and/or independent external review rights (an "Administrative Claim"). A claimant must raise every argument and/or produce all evidence the claimant believes supports the claim or action in the Administrative Claim and shall be deemed to have waived any argument and/or the right to produce any evidence not submitted to the Administrator or its delegate as part of the Administrative Claim.

Any Judicial Claim must be commenced in the appropriate court or forum no later than 24 months from the earliest of (A) the date the first benefits were paid or allegedly due; (B) the date the Administrator or its delegate first denied the claimant's request; or (C) the first date the claimant knew or should have known the principal facts on which such claim or action is based; provided, however, that, if the claimant commences an Administrative Claim before the expiration of such 24 month period, the period for

commencing a Judicial Claim shall expire on the later of the end of the 24 month period and the date that is 3 months after final denial of the claimant's Administrative Claim, such that the claimant has exhausted the Plan's claims and appeals procedures. Any claim or action that is commenced, filed or raised, whether a Judicial Claim or an Administrative Claim, after expiration of such 24-month period (or, if applicable, expiration of the 3-month period following exhaustion of the Plan's claims and appeals procedures) shall be time-barred. Filing or commencing a Judicial Claim before the claimant exhausts the Administrative Claim requirements shall not toll the 24-month limitations period (or, if applicable, the 3 month limitations period).

Judicial claims must be brought in the United States District Court for the District of Columbia.

Acts of Third Parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (Medical, including prescription drug, Dental Vision, and disability) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek on its own behalf, expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable to) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;

- May appoint you (or your attorney or other representative) as constructive trustee for any and all monies paid (or payable to) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is caused by a third party, you agree to place the funds in a separate,

identifiable account and that the Plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.

- If requested, to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.

- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits (including those of another person in the family) until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

The reduction and/or offset noted above shall be accomplished by the plan as a right of administrative set off without the need to initiate any legal action. Such reduction and/or offset may occur from and after a designated date, even if plan benefits were not reduced and/or offset prior to a designated date.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Non-assignment of Rights or Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit or their rights under the

Plan. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, all or a portion of benefits provided by the Plan may, at the option of the Plan, be paid directly to the person rendering such service but this will be done as a convenience to you and will not constitute an assignment of benefits or rights under the Plan. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Company to the extent of such payment.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Coordination of Benefit Rules

The Plan contains a provision called "coordination of benefits" ("COB"). This feature is designed to coordinate your medical benefit coverage with other coverages and prevent a duplication of benefit payments. Under COB, the total benefits paid by all plans combined will not exceed 100% of your allowable medical expenses. Please refer to the applicable EOC for more information.

The COB feature applies when you or any of your covered dependents are eligible for medical benefits (in addition to those provided under the Plan) from another source such as:

- A group-sponsored insurance or prepayment plan (such as your spouse's group medical plan, another employer's group medical plan or a retiree group medical plan),
- A legal settlement that includes all or part of the cost of the medical care, or
- A government-sponsored plan.

COB rules apply to you and all of your covered eligible dependents. However, COB does not apply to any personal insurance policy (except no-fault or other state-mandated automobile insurance).

Coordination with Medicare

The Plan intends for Medicare to be the primary payer to the full extent permitted by law. In general, if you are in current employment status, Medicare will be the secondary payer and the Company's medical plan will pay primary (special rules apply to those with end-stage renal disease). Please refer to the EOC for more information.

Benefits for Disabled Individuals

If you stop working at the Company because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for

Medicare Parts A and B. Medicare Part A provides inpatient hospitalization benefits, and Medicare Part B provides outpatient medical benefits, such as doctor's office visits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for employees who qualify for Medicare because of disability, Medicare generally is the primary payer; in other words, **your claims go to Medicare first**. If Medicare pays less than the current benefit allowable by the Plan, the Plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

When Medicare is the primary payer (or would be the primary payer if you enrolled), no benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States.

Contact your local Social Security office for more information on Medicare benefits.

No Tax, Investment or Legal Advice

The Company cannot advise you regarding tax, investment, or legal advice regarding the Smiths Group benefit plans. Therefore, if you have questions regarding your benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor).

Plan Continuation and Reservation of Rights

The Company presently intends to continue the Plan but reserves the right to amend, suspend, discontinue, or terminate the Plan, in whole or in part, at any time.

The Company's decision to amend, suspend, discontinue, or terminate the Plan, in whole or in part, may be due to changes in federal or state laws governing welfare or other benefits, the requirements of the Internal Revenue Code or the ERISA, the provision of a contract or policy involving an insurance company, Company policy, or any other reason.

If the Plan is terminated, in whole or in part, you will not have any further rights other than payment of expenses or other claims incurred before the Plan was terminated. After all benefits have been paid and other requirements of law have been met, any remaining Plan assets will be, at the discretion of the Company, either used to purchase benefits or distributed to Plan participants in accordance with the requirements of law.

Administrative Information

Below is key information you need to know about your benefit plans:

Plan Name	Smiths Group Services Corp. Welfare Plan ("Smiths Group Plan")
Plan Number	501
Plan Sponsor	Smiths Group Services Corp. 25 Massachusetts Ave. NW, Suite 120 Washington DC 20001
Employer Identification Number	22-3015350
Plan Administrator	Smiths Group Services Corp. 25 Massachusetts Ave. NW, Suite 120 Washington DC 20001 1-866-330-6555
Plan Administration Type	Insurance company and third-party administrator
Agent for Service of Legal Process	Plan Administrator
Plan Year	August 1 through July 31
Plan Type	Welfare benefit plan providing the following types of benefits: • Medical (includes prescription drug) • Wellness • Dental • Vision • Long-Term Disability (Basic and Buy-Up) • Basic Life Insurance • Supplemental Life Insurance • Dependent Life Insurance • Accidental Death and Dismemberment (AD&D) • Voluntary AD&D • Health Care Flexible Spending Account • EAP • Hospital, indemnity and other voluntary benefits Although the Dependent Care Flexible Spending account is described in this SPD, it is not an ERISA plan. Although the Health Savings Account is referenced in this SPD, it is also not an ERISA plan.

Source of Contributions	Depending on the benefits selected by the employee, the cost of contributions for certain of the benefits offered within the Plan will either be covered by contributions from Smiths Group Service Corp., contributions by the employee, or will be shared by Smiths Group Services Corp. and the employee. The cost of Medical (which includes Prescription Drug), Dental and Vision coverage is shared by Smiths Group Services Corp. and its employees enrolled in those coverages. Smiths Group Services Corp. pays 100% of the cost of the Basic Life and AD&D coverages. Employees pay 100% of the Supplemental Life, Dependent Life, LTD, Voluntary AD&D, and other Voluntary Benefits and contributions to the Health Care and Dependent Care Flexible Spending Accounts and Health Savings Account. Where Smiths Group Services Corp. and employees share the cost of coverage, Smiths Group Services Corp. shall contribute the difference between the amount employees are required to contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. Smiths Group Services Corp., in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse Smiths Group Services Corp. for its contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Plan Document

This document, combined with the separate SPD for the Flexible Benefits Plan and separate booklets for the various benefits, together are intended to serve as the summary plan description under ERISA of the official Plan document. This SPD alone is not intended to serve as the official Plan document, which governs the operation of the Plan. In the event of a disagreement between the SPD and insurance contracts or vendor booklets, the provisions of the insurance contracts or vendor booklets, as

amended from time to time, will govern. To request a copy of the insurance contracts or vendor booklets, please contact the Plan Administrator.

Plan Amendment and Termination

Smiths Group Services Corp. reserves the right to amend, modify or suspend the Plan in whole or in part or to terminate or completely discontinue the Plan at any time. For example, Smiths Group Services Corp. reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require, revise or increase employee contributions. Smiths Group Services Corp. also reserves the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third party administrators, and/or service providers, to amend the Plan to implement any cost control measures that it may deem advisable and to revise the amount of employee contributions. Employees will be notified of any material modifications to the Plan.

Any amendment, termination or other action by Smiths Group Services Corp. will be done in accordance with Smiths Group Services Corp.'s normal operating procedures. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be retroactive to the extent necessary to comply with applicable law. No amendment, modification, suspension or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Smiths Group Services Corp., the Plan shall terminate unless the Plan is continued by a successor to Smiths Group Services Corp.

Plan Administration

Smiths Group Services Corp. is responsible for the general administration of the Plan and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an EOC. Smiths Group Services Corp. has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Smiths Group Services Corp. will make such adjustment on account of the mistake as it considers equitable and practicable, considering applicable law. Neither the Plan Administrator nor Smiths Group Services Corp. will be liable in any manner for any determination made in good faith.

Smiths Group Services Corp. may designate other organizations or persons to carry out specific fiduciary responsibilities for Smiths Group Services Corp. in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative service or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,

- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and

- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Smiths Group Services Corp. will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Power and Authority of the Insurance Company

The Life, Dependent Life, Supplemental Life, AD&D, Voluntary AD&D and LTD and other Voluntary benefits under this Plan are fully insured. Benefits may be provided under a group insurance contract entered into between Smiths Group Services Corp. and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. In addition, there may be separate medical plan options that are fully insured. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not Smiths Group Services Corp.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan.

- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to your EOCs or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts, EOCs, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Association. There is no charge for this review.

- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including EOCs and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy

of Plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the Plan's claims and appeals procedures as described above. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272 or logging on to www.dol.gov/ebsa.

Appendix A — Evidence of Coverage Documents

This summary should be read in combination with the insurance contracts, evidence of coverage documents, and benefit booklets (together and individually referred to as “EOCs”) provided by the insurance companies and service providers.

The EOCs are intended to describe the Smiths Group Service Corp. benefits available to you as an employee of Smiths Group Service Corp., and, when read with this summary, are intended to meet ERISA’s SPD requirements.

Please see the EOCs for details of Plan benefits.

For additional information or for copies of the EOCs, please contact the Plan Administrator.

Coverage	Evidence of Coverage Name
Medical PPO	Anthem Medical Benefit Booklet Smiths Group Americas, LLC PPO 08/01/2021 Anthem Blue Cross Blue Shield
Medical HDHP (Advantage HSA)	Anthem Medical Benefit Booklet Smiths Group Americas, LLC Advantage HSA 08/01/2021 Anthem Blue Cross Blue Shield
Prescription Drug (provided to those enrolled in the Anthem medical plans)	CVS Caremark www.caremark.com
Dental	Delta Dental Evidence of Coverage Smiths Group Services Corp. (Basic Option) Group Number: 9156 Effective Date: 08/01/2020 Delta Dental Evidence of Coverage Smiths Group Services Corp. (Enhanced Option) Group Number: 9156 Effective Date: 08/01/2020
Vision	EyeMed (Core or Enhanced) Smiths Group North America, Inc.

Basic Life Insurance, Supplemental Life, Dependent Life, AD&D, Voluntary AD&D	Employee Term Life Coverage; Basic and Optional Plans Dependents Term Life Coverage Accidental Death and Dismemberment Coverage; Basic and Optional Plans Prudential Financial
Long-Term Disability	Long-Term Disability Benefit Certificate Smiths Group North America, Inc. Corporate G-66263-PA 08/01/2020
Flexible Spending Accounts	Flexible Benefits Plan SPD Refer to Smiths Group Benefits Center 866-330-6555
Voluntary Benefits **Group Critical Illness Insurance** **Group Accidental Injury Insurance** **Group Supplemental Hospital Indemnity**	Aflac/Continental American Insurance Co. P.O. Box 84075 Columbus, Georgia, 31993-9103 800-433-3036
Legal Benefits (effective 8/1/24)	**MetLife** 1111 Superior Avenue Cleveland, OH 44114-2507 1-800-821-6400